RANDY LAW, CLERK OF COURTS
2026 CV 01263 STK
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IN THE COURT OF COMMON PLEAS
TRUMBULL COUNTY, OHIO

ESTATE OF MARGARET A. LIGHTNER, DECEASED Through Estate Representative Candace Lightner c/o Michael Hill Trial Law 815 Superior Avenue, Suite 623 Cleveland, Ohio 44114 Plaintiff, vs. WARREN NURSING & REHAB AKA WARREN NURSING & REHAB – PROVIDING ONSITE DIALYSIS & VENTILATOR AKA 2473 NORTH ROAD NE OPCO, LLC 2473 North Road NE Warren, OH 44483 Also Serve c/o Registered Agent: Taft Service Solutions Corp. 301 East Fourth Street, Suite 2800 Cincinnati, OH 45202 and GARDEN SPRINGS HEALTHCARE AKA GARDEN SPRINGS, LLC 30100 Chagrin Boulevard, Suite 202 Pepper Pike, OH 44124 Also Serve c/o Registered Agent: Taft Service Solutions Corp. 301 East Fourth Street, Suite 2800 Cincinnati, OH 45202 and CASTLE ROCK NURSING MEMBER, LLC c/o Registered Agent: Taft Service Solutions Corp. 301 East Fourth Street, Suite 2800	CASE NO. JUDGE **COMPLAINT** **WITH JURY DEMAND ENDORSED HEREON** **MOTION TO EXTEND DEADLINE TO FILE AFFIDAVIT OF MERIT FILED CONCURRENTLY**

Cincinnati, OH 45202)
)
and)
)
PHILIPSON FAMILY LIMITED LIABILITY COMPANY, LLC)
908 88th Street)
Surfside, FL 33154)
)
and)
)
YFR EQUITIES, LLC)
c/o Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator)
2473 North Road NE)
Warren, OH 44483)
)
and)
)
2473 NORTH ROAD NE PROPCO, LLC)
c/o Registered Agent:)
Taft Service Solutions Corp.)
301 East Fourth Street, Suite 2800)
Cincinnati, OH 45202)
)
)
Defendants)

Plaintiff, the Estate of Margaret A. Lightner, Deceased, through Estate Representative Candace Lightner, for this Complaint against the above-named Defendants, states and avers upon information and belief:

INTRODUCTION

1. This action involves multiple claims (medical negligence, recklessness, wrongful death, Resident's Rights Law violations, civil conspiracy, and fraud) involving Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator's ("Facility's") inadequate care of Margaret Lightner and the corporate control

of the facility leading to such inadequate care that led to Margaret Lightner's untimely and wrongful death on May 7, 2025.

2. Defendants accepted sixty-year-old Margaret Lightner as a short-term rehabilitation resident on or about March 31, 2025, to provide rehabilitation care and treatment as she recovered from surgery to repair a broken vertebra in her spine.

3. Margaret Lightner's back surgery and hospitalization went smoothly, and her attending surgeon and treating doctors expected Margaret to make a full recovery and return to living independently at home after a short course of rehabilitation.

4. At the time Defendants accepted Margaret Lightner as a short-term rehabilitation resident, Margaret was prescribed pain medications by her treating doctors to reduce the pain from her broken vertebra and surgery.

5. Defendants knew that Margaret Lightner's treating doctors prescribed pain medications to her, and also knew that these pain medications can cause severe constipation.

6. While under the Defendants' care and supervision in late March through early May 2025, the Defendants failed to monitor Margaret for signs and symptoms of constipation, missing completely that Margaret had not had a bowel movement for several weeks.

7. For several days before May 7, 2025, Margaret developed nausea and vomiting and was not acting like her usual self, becoming withdrawn and lethargic.

8. On May 6, 2025, Margaret Lightner's family found her in her room at Defendants' facility in serious distress. Margaret's skin had a gray appearance, she was barely responsive, and had a noticeable change from her usual upbeat demeanor.

9. Margaret's daughter insisted that Defendants' staff call an ambulance to transfer Margaret to the emergency room at St. Joseph Warren Hospital.

10. Upon arrival at St. Joseph Warren Hospital, Margaret Lightner was evaluated by emergency department physicians who determined that Margaret was suffering from a severe fecal impaction – a hardened and compressed mass of stool in her large intestine formed from being constipated for as long as several weeks.

11. The compressed mass of stool in Margaret's colon stretched and compressed the walls of her colon as it grew larger and harder, resulting in portions of her colon losing blood flow and dying off.

12. As portions of Margaret's colon died off from lack of blood flow due to the fecal impaction, the dead tissues of her colon ruptured – called a colon perforation – causing feces and bacteria to leak into her abdomen leading to infection and a life-threatening medical emergency.

13. The physicians treating Margaret Lightner concluded she needed an emergency surgery to try to repair her perforated colon and clean out the feces leaking into her abdomen. During the procedure, her colon was so damaged and had so much dead and necrotic tissue that her colon could not be saved and the surgeons had to remove her entire colon.

14. Following the surgery, Margaret Lightner remained extremely ill and unstable from the severe shock to her system caused by the infection and the extensive surgery to remove her dead and necrotic bowel.

15. On May 7, 2025, Margaret Lightner died. Her death certificate lists the cause of death as septic shock due to a perforated colon.

16. Plaintiff requests a trial by jury.

17. Plaintiff brings this action for compensation for the harms and losses sustained as the result of the negligence, recklessness, conscious disregard, reckless disregard, conduct by which—through heedless indifference to the consequences—the Defendants or their staff disregarded a substantial and unjustifiable risk that the health care provider's conduct is likely to cause, at the time those services or that treatment or care were rendered, an unreasonable risk of injury, death, or loss to person or property, or intentional misconduct or willful or wanton misconduct, and other wrongful conduct described herein or discovered during litigation.

DEFENDANTS

18. Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator aka 2473 North Road NE Opco, LLC is an Ohio corporation that holds itself out to the public as a provider of medical and nursing care, including but not limited to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees and does business as Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator.

19. Garden Springs Healthcare aka Garden Springs, LLC is an Ohio corporation that holds itself out to the public as a provider of medical and nursing care, including but not limited to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees and does business as Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator.

20. Castle Rock Nursing Member, LLC is an Ohio corporation that holds itself out to the public as a provider of medical and nursing care, including but not limited to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees

and does business as Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator.

21. Philipson Family Limited Liability Company, LLC is a New York corporation that holds itself out to the public as a provider of medical and nursing care, including but not limited to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees and does business as Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator.

22. YFR Equities, LLC is a New York corporation that holds itself out to the public as a provider of medical and nursing care, including but not limited to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees and does business as Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator.

23. Castle Rock Nursing Member, LLC is an Ohio corporation that holds itself out to the public as a provider of medical and nursing care, including but not limited to, rehabilitation and skilled nursing care, through its agents, operatives and / or employees and does business as Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator.

24. The Defendants employ, manage, and direct the care and service providers who were responsible for Margaret Lightner's care, treatment, and safety at Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator while they were a resident there, and / or are responsible for creating unsafe conditions at the Facility through their control of the Facility management that directly led to Marget Lightner's injuries and untimely and wrongful death on May 7, 2025.

25. The Defendants direct and control operations at the Facility and are therefore directly liable for mismanagement of the Facility without regard to piercing the corporate veil.

26. The Defendant organization controls the other corporations in a way that is so complete that the corporations have no separate mind, will, or existence of their own, is exercised in such a manner as to commit fraud or an illegal act against the person seeking to disregard the corporate entity; and injury or unjust loss resulted to the plaintiff from such control and wrong, meaning the Defendants should be held directly liable for such harms and losses.

27. The Defendants collectively own, manage, control, and/or are responsible for the care delivered to residents of Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator, directly or through their domination and control of any putative entity license holder.

VICARIOUS LIABILITY

28. The Defendants employ the care providers who were responsible for ensuring Margaret Lightner's care and safety.

29. The Defendants manage, control, and/or employ the nursing staff at the Facility.

30. Margaret Lightner and her family looked to the Defendants for care based upon their representations.

31. The Defendants are vicariously liable for the negligent actions of their employees and agents (respondeat superior and agency liability) and/or independent contractors (Clark v. Southview agency by estoppel), including visiting physicians and

nurse practitioners contracted with any of the Defendants and / or provided to residents as default or house care providers.

JURISDICTION AND VENUE

32. This Court has Jurisdiction over Defendants because, among other things, all Defendants do, and all times relevant did, purposefully avail themselves of the laws of the State of Ohio, and/or committed tortious acts within the State of Ohio.

33. Venue is proper in Trumbull County, Ohio under Civil Rule 3(B) because, among other reasons: (a) one or more Defendants reside, domicile, or carry on their principal place of business in that county; and (b) part of the claim for relief arose in that county.

COMMON FACTS

34. Defendants hold themselves out to the public as providers of long-term nursing home, skilled nursing, and memory care services.

35. Defendants' for-profit model means their primary goal is to maximize profit, measured by revenues minus expenses.

36. For nursing homes generally, the largest individual revenue source is residents (filling beds), and the largest individual expense is the cost of employing nursing staff to provide care to those residents. This creates a financial incentive to take on more residents with greater care needs than the nursing staff can properly care for, a violation of federal nursing home regulations regarding staffing levels.

37. The Defendants manage, control, and / or employ the nursing staff at Facility.

38. The Defendants exercise actual control over the Facility's management and operations to maximize profits, including control over facility-level:

a. Policies and procedures, including regarding resident care;

b. Finances, including obtaining credit and loans, guaranteeing loans (both at the corporate and individual facility level), maintaining funds and banking, obtaining, owning, and leasing facility land and buildings, and capital expenditures.

c. Budgeting, including controlling the amount of funds available for staffing facilities;

d. Personnel management, including hiring and firing, or having authority to hire and fire, the supervisory and management personnel in each facility;

e. Supervision of management, care providers, and staff in each facility, including compliance with federal and state regulations;

f. Employment, such as setting pay scales, shifts, and time and vacation policies;

g. Systems for training, monitoring, and supervising staff;

h. Medical record systems and management;

i. Financial control systems, including budgeting and payment processing;

j. Marketing, including setting the image and expectations residents and their family should expect at the facility, and even the name of the facility;

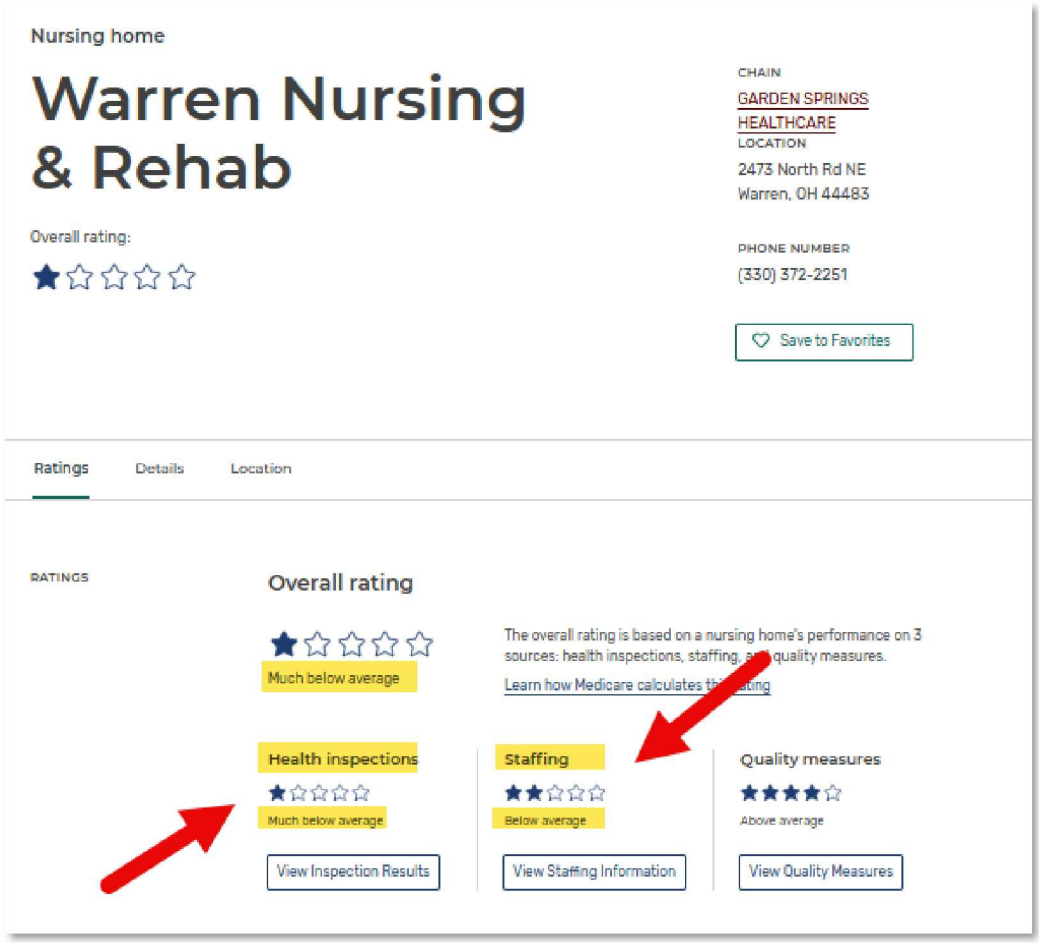
k. Reporting procedures, including reporting to Medicare as to individual resident care and facility-wide issues.

39. As the result of this control, the Defendants make decisions that affect the day-to-day care of residents of the Facility, such as the resources available for providing nursing staff and care to residents like Margaret Lightner, meaning they are responsible for the foreseeable harm that results from careless decisions while voluntarily exercising that control.

40. Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that the facilities were sufficiently staffed to meet the individual needs of its residents, including Margaret Lightner.

41. Defendants engaged in a systemic practice to understaff the facilities to maximize profits at the expense of its residents' care.

42. The Defendants' systemic understaffing of the Facility resulted in a "1-star" (" much below average") overall ranking, with a "2-star" or "below average" ranking for Staffing on the Medicare.gov Nursing Home Compare website.



According to the Centers for Medicare and Medicaid, Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator earned a 1-star, or "much below average" rating for Health Inspections and a 2-star or "below average" rating for Staffing. This data was taken directly from medicare.gov on April 23, 2026.

43. This lack of sufficient staff directly resulted in Margaret Lightner not receiving basic and necessary services to prevent, among other things, neglect leading to their injuries and death.

44. The Defendants also exercise operational and managerial control, and apply this profits-over-safety model, at the following facilities in the State of Ohio:

a. Autumnwood Care Center
670 OH-18
Tiffin, OH 44883

b. Bethesda Care Center
600 N. Brush Street
Fremont, OH 43420

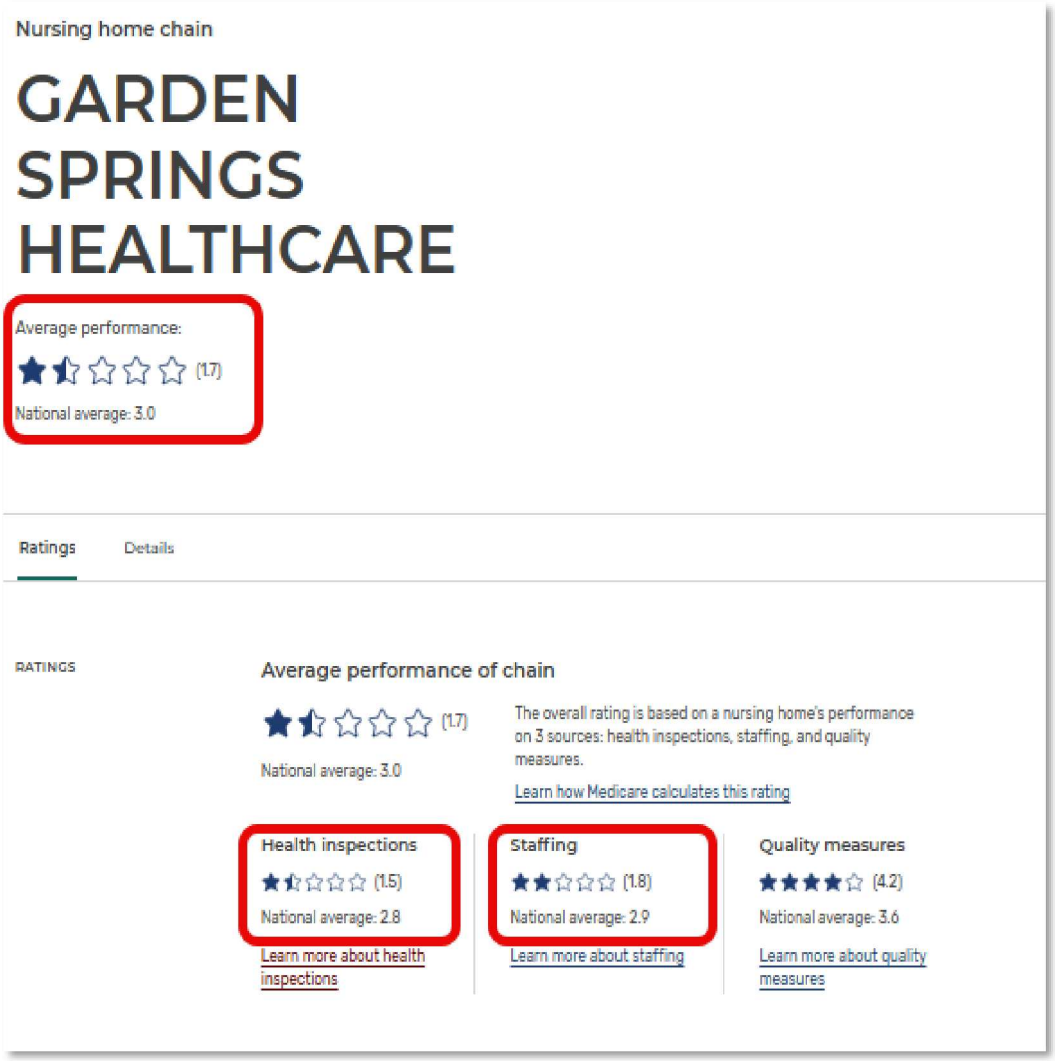
c. Eastbrook Healthcare
17322 Euclid Avenue
Cleveland, OH 44112

d. Hudson Springs Nursing and Rehab
5000 Sowul Boulevard
Stow, OH 44224

e. Marion Rehabilitation
175 Community Drive
Marion, OH 43302

f. Newark Rehabilitation
75 McMillen Drive
Newark, OH 43055

45. The Defendants' profits-over-safety model and systemic understaffing, applied across the entire chain of nursing homes owned and operated by the Defendants, has resulted in an average ranking of "1.8-star" ranking for Staffing across all the Defendants' nursing homes on Medicare.gov Nursing Home Compare website and a "1.7-star" ranking overall.



According to the Centers for Medicare and Medicaid, the Garden Springs Healthcare chain of nursing homes average a "1.8-star" rating for Staffing, below the national average of 2.9 stars, and a "1.5-star" rating for Health Inspections, below the national average of 2.8 stars. This data was taken directly from medicare.gov on April 23, 2026.

Reporting Data – Nursing Home

46. The Defendants are required to report significant amounts of data to the federal agency that oversees operations of nursing homes receiving federal or state funding, the Centers for Medicare and Medicaid Services, or "Medicare."

47. The data the Defendants submit to Medicare regarding its facility includes data on its residents (numbers, care needs, and bed days), its finances, and its nurse and nursing aide staffing levels as compared to resident care needs.

48. This data is certified correct by the Defendants and / or submitted under penalty of perjury and / or civil or criminal penalties.

49. Medicare uses some of this data submitted by Defendants to produce its nursing home 5-star rating system, also known as "Nursing Home Compare."

Nursing Home Resident Care Needs and Staffing Levels (MDS and PDPM Scores)

50. Every nursing home receiving Medicare or Medicaid funding—the clear majority of nursing homes, including Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator and others operated and / or controlled by Defendants—is required to provide detailed information regarding the health status, care and treatment, and services provided to each resident in the facility using a questionnaire called the Minimum Data Set, or MDS. This evaluation is done for all nursing home residents regardless of whether their care is being paid for by Medicare.

51. Nursing homes like Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator are required to evaluate every resident using the Minimum Data Set questionnaire shortly after the time of admission, every 90 days thereafter, when a resident has a significant improvement or decline in health (physical, mental, or psychosocial), and upon discharge.

52. Based on this Minimum Data Set, each resident's individual care needs (called "acuity level") are assigned into a group signifying how much nursing or staff care the resident requires, called a Patient-Driven Payment Model score, or PDPM score. The

PDPM score is calculated for physical therapy, occupational therapy, speech-language pathology, non-therapy ancillary services, and nursing services.

53. Each resident's PDPM score for nursing services is contained in the patient's Minimum Data Set evaluations, meaning the total nursing care needs of the residents in any facility at a specific time is available by totaling the residents' PDPM scores from various sections of the Minimum Data Set evaluations corresponding to increased needs for nursing care.

54. When these PDPM scores are combined for all residents in a nursing home facility, the nursing home knows exactly how many minutes of nursing and nursing aide care should be provided, on average, to meet the expected care needs of their residents.

Misleading Advertising

55. In an effort to persuade the families of patients to become customers, Defendants make promises to the families of such potential residents that they will provide a level of care that they know they are incapable of providing.

56. The intent and outcome of this misleading practice is to cause residents, their families, and external care providers to believe the nursing facility is much better staffed to provide the promised care than what is actually the practice of the Defendants with regard to staffing the Facility.

57. The intent and outcome of this misleading practice is to drastically limit the budget and overhead needed to run a safe facility in order to maximize profits and syphon resources at the expense of patient safety.

Systemic Understaffing and Margaret Lightner's Care

58. Defendants failed to ensure, through their operational, budgetary, consultation and managerial decisions and actions, that Warren Nursing & Rehab aka

Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator, was sufficiently staffed, and the staff appropriately trained and informed, to meet the individual needs of Margaret Lightner during the period she was a resident at the facility.

59. Defendants engaged in a systemic practice to understaff Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator to maximize profits at the expense of its residents' care.

60. This lack of sufficient staff directly resulted in Margaret Lightner not receiving basic and necessary services, assessments, and interventions to prevent, among other things, neglect leading to their injuries at Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator during the period she was a resident at the Facility.

Defendants' Negligence and Recklessness with Margaret Lightner

1. Defendants accepted sixty-year-old Margaret Lightner as a short-term rehabilitation resident on or about March 31, 2025, to provide rehabilitation care and treatment as she recovered from surgery to repair a broken vertebra in her spine.

2. Margaret Lightner's back surgery and hospitalization went smoothly, and her attending surgeon and treating doctors expected Margaret to make a full recovery and return to living independently at home after a short course of rehabilitation.

3. At the time Defendants accepted Margaret Lightner as a short-term rehabilitation resident, Margaret was prescribed pain medications by her treating doctors to reduce the pain from her broken vertebra and surgery.

4. Defendants knew that Margaret Lightner's treating doctors prescribed pain medications to her, and also knew that these pain medications can cause severe constipation.

5. While under the Defendants' care and supervision in late March through early May 2025, the Defendants failed to monitor Margaret for signs and symptoms of constipation, missing completely that Margaret had not had a bowel movement for several weeks.

6. For several days before May 7, 2025, Margaret developed nausea and vomiting and was not acting like her usual self, becoming withdrawn and lethargic.

7. On May 6, 2025, Margaret Lightner's family found her in her room at Defendants' facility in serious distress. Margaret's skin had a gray appearance, she was barely responsive, and had a noticeable change from her usual upbeat demeanor.

8. Margaret's daughter insisted that Defendants' staff call an ambulance to transfer Margaret to the emergency room at St. Joseph Warren Hospital.

9. Upon arrival at St. Joseph Warren Hospital, Margaret Lightner was evaluated by emergency department physicians who determined that Margaret was suffering from a severe fecal impaction – a hardened and compressed mass of stool in her large intestine formed from being constipated for as long as several weeks.

10. Upon arrival at St. Joseph Warren Hospital, Margaret was taken for emergency surgery due to a perforated colon—a rupture of the colon that causes feces and bacteria to leak into the abdomen, leading to infection and a life-threatening medical emergency. During the procedure, surgeons were required to remove her entire colon. It was reported that Ms. Margaret had not had a bowel movement for a matter of weeks before her hospitalization.

11. On May 7, 2025, Margaret Lightner died. Her death certificate lists the cause of death as septic shock due to a perforated colon.

12. Margaret Lightner endured mental and physical pain suffering and death as a direct and proximate result of Defendants' failure to provide adequate care due to understaffing the facility.

FIRST CAUSE OF ACTION
(MEDICAL NEGLIGENCE / RECKLESSNESS)

13. Plaintiff incorporates all other paragraphs of this Complaint as if fully rewritten herein.

14. Margaret Lightner depended on the Defendants, and their respective nursing and medical staff, for medical and nursing care, treatment, evaluation, and assistance.

15. The Defendants had a duty to provide proper care and treatment to Margaret Lightner and to avoid causing injury to her.

16. The Defendants, including their medical and nursing staff, failed to provide proper care and treatment to Margaret Lightner, which they knew or should have known she required, and their negligence was the direct and proximate cause of the injuries that Margaret Lightner suffered.

17. The Defendants' failure to provide proper care and treatment included, but is not limited to:

a. Choosing to put inadequate prevention and response interventions in place to prevent injuries;

b. Choosing to provide inadequate resident observation, supervision, and monitoring;

c. Choosing to provide improper training to staff members regarding resident monitoring, assessment, response, and treatment;

d. Choosing to provide too few, and / or underqualified nursing staff members for resident needs at each facility to protect and provide adequate care to residents like Margaret Lightner;

e. Choosing not to provide accurate, adequate, or timely information to Margaret Lightner's family;

f. Choosing to provide inadequate supervision to prevent accidents and falls;

g. Choosing to violate orders relating to the care of Margaret Lightner;

h. Choosing to violate state and federal regulations governing care and staffing levels in nursing home facilities, in which residents like Margaret Lightner are a member of the class of persons intended to be protected from injuries like those she suffered;

i. Failing to ensure the rights and safety of its residents, including Margaret Lightner, as required by Ohio and federal regulations;

j. Choosing not to provide appropriate care to Margaret Lightner while she was a resident of the Facility; and

k. Such other acts or omissions described in this Complaint or discovered in litigation.

18. These actions constituted a conscious disregard for Margaret Lightner's rights and safety with a great probability of causing substantial harm from this misconduct, by which—through heedless indifference to the consequences—the Defendants or their staff disregarded a substantial and unjustifiable risk that the health care provider's conduct was likely to cause, at the time those services or that treatment or care were rendered, constituting an unreasonable risk of injury, death, or loss to person or property, or intentional misconduct or willful or wanton misconduct. The Defendants were aware of the great probability of the harm that could result from their willful, wanton, and/or reckless misconduct.

19. The Defendants' disregard for the rights and safety of residents like Margaret Lightner created circumstances under which it became substantially certain that serious injuries would result, entitling Plaintiff to awards for compensatory and punitive damages.

20. The Defendants are directly liable for their own willful, wanton, and/or reckless misconduct.

21. The Defendants are also vicariously liable for their employees' and agents' willful, wanton, and/or reckless misconduct.

22. The Defendants and their medical and nursing staff provided care to Margaret Lightner that fell below the standard of care expected of medical care and nursing home organizations, under the same or similar circumstances.

23. The departures from the standard of care are evidenced by violations of sections of Federal Regulations, 42 C.F.R. § 483 et seq., and Ohio Administrative Code sections, OAC 3701-17 et seq., and the Ohio Resident's Rights Law, R.C. section 3721.13.

24. As a direct and proximate result of the negligent and/or willful, wanton and/or reckless actions of the Defendants described above, Margaret Lightner sustained permanent injury and loss, including, but not limited to, conscious pain and suffering, disability, and death.

25. WHEREFORE, Plaintiff demands judgment against the Defendants, jointly, in an amount more than Twenty-Five Thousand Dollars ($25,000.00), for conscious pain and suffering, loss of enjoyment, together with costs of suit, attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the Plaintiff may be entitled to and/or that the court finds is appropriate and/or equitable.

SECOND CAUSE OF ACTION
(WRONGFUL DEATH)

26. Plaintiff incorporates all other paragraphs of this Complaint as if fully rewritten herein.

27. Margaret Lightner depended on the Defendants, and their respective nursing and medical staff, for medical and nursing care, treatment, evaluation, and assistance.

28. The Defendants had a duty to provide proper care and treatment to Margaret Lightner and to avoid causing injury to her.

29. The Defendants, including their medical and nursing staff, failed to provide proper care and treatment to Margaret Lightner, which they knew or should have known she required, and their negligence was the direct and proximate cause of the injuries that Margaret Lightner suffered.

30. The Defendants' failure to provide proper care and treatment included, but is not limited to:

a. Choosing to put inadequate prevention and response interventions in place to prevent injuries;

b. Choosing to provide inadequate resident observation, supervision, and monitoring;

c. Choosing to provide improper training to staff members regarding resident monitoring, assessment, response, and treatment;

d. Choosing to provide too few, and / or underqualified nursing staff members for resident needs at each facility to protect and provide adequate care to residents like Margaret Lightner;

e. Choosing not to provide accurate, adequate, or timely information to Margaret Lightner's family;

f. Choosing to provide inadequate supervision to prevent accidents and falls;

g. Choosing to violate orders relating to the care of Margaret Lightner;

h. Choosing to violate state and federal regulations governing care and staffing levels in nursing home facilities by which residents like Margaret Lightner are a member of the class of persons intended to be protected from injuries like those she suffered;

i. Failing to ensure the rights and safety of its residents, including Margaret Lightner, as required by Ohio and federal regulations;

j. Choosing not to provide appropriate care to Margaret while she was a resident of the Facility; and

k. Such other acts or omissions described in this Complaint or discovered in litigation.

31. Defendants, directly or through their employees or agents, violated Margaret Lightner's rights as a resident of the Defendants' facilities, as enumerated in Ohio Revised Code section 3721.13, including, but not limited to:

a. The right to a safe and clean living environment;

b. The right to be free from physical, verbal, mental, and emotional abuse and to be treated at all times with courtesy, respect, and full recognition of dignity and individuality;

c. The right to adequate and appropriate medical treatment and nursing care and to other ancillary services that comprise necessary and appropriate care;

d. The right to have clothes and bed sheets changed as the need arises, to ensure the resident's comfort or sanitation;

e. The right to participate in decisions that affect the resident's life;

f. The right to have any significant change in the resident's health status reported to the resident's sponsor.

32. These violations are evidence of negligence and conscious disregard of Margaret Lightner's rights and safety and give rise to a statutory cause of action.

33. Margaret Lightner endured conscious pain, suffering, and disability, and other harms and losses as the direct and proximate result of Defendants' violations of R.C. 3721.13.

34. These actions constituted a conscious disregard for Margaret Lightner's rights and safety with a great probability of causing substantial harm from this misconduct, by which—through heedless indifference to the consequences—the

Defendants or their staff disregarded a substantial and unjustifiable risk that the health care provider's conduct was likely to cause, at the time those services or that treatment or care were rendered, constituting an unreasonable risk of injury, death, or loss to person or property, or intentional misconduct or willful or wanton misconduct.

35. The Defendants were aware of the great probability of the harm that could result from their willful, wanton, and/or reckless misconduct.

36. The Defendants' disregard for the rights and safety of residents like Margaret Lightner created circumstances under which it became substantially certain that serious injuries would result.

37. The Defendants are directly liable for their own willful, wanton, and/or reckless misconduct.

38. The Defendants are also vicariously liable for their employees' and agents' willful, wanton, and/or reckless misconduct.

39. The Defendants and their medical and nursing staff provided care to Margaret Lightner that fell below the standard of care expected of medical care and nursing home organizations, under the same or similar circumstances.

40. The departures from the standard of care are evidenced by violations of sections of Federal Regulations, 42 C.F.R. § 483 et seq., and Ohio Administrative Code sections, OAC 3701-17 et seq., and the Ohio Resident's Rights Law, R.C. section 3721.13.

41. As a direct and proximate result of the negligence / recklessness described above, Margaret Lightner sustained injuries that caused her untimely and wrongful death.

42. Margaret Lightner's next-of-kin suffered damages as set forth in the Ohio Wrongful Death statute, R.C. 2125.01 et seq., including mental anguish and grief and loss of Decedent's society and companionship.

43. WHEREFORE, Plaintiff demands judgment against Defendants, in an amount more than $25,000.00 to compensate the decedent's next of kin and heirs at law, together with costs of suit, attorneys' fees and expenses, and any other relief the court finds is appropriate and / or equitable.

THIRD CAUSE OF ACTION
(NURSING HOME RESIDENT RIGHTS VIOLATION R.C. 3721.13)

44. Plaintiff incorporates all other paragraphs of this Complaint as if fully rewritten herein.

45. Defendants, directly or through their employees or agents, violated Margaret Lightner's rights as a resident of the Defendants' facilities, as enumerated in Ohio Revised Code section 3721.13, including, but not limited to:

a. The right to a safe and clean living environment;

b. The right to be free from physical, verbal, mental, and emotional abuse and to be treated at all times with courtesy, respect, and full recognition of dignity and individuality;

c. The right to adequate and appropriate medical treatment and nursing care and to other ancillary services that comprise necessary and appropriate care;

d. The right to have clothes and bed sheets changed as the need arises, to ensure the resident's comfort or sanitation;

e. The right to participate in decisions that affect the resident's life;

f. The right to have any significant change in the resident's health status reported to the resident's sponsor.

46. These violations are evidence of negligence and conscious disregard of Margaret Lightner's rights and safety, and give rise to a statutory cause of action.

47. As a direct and proximate result of Defendants' violations of R.C. 3721.13, Margaret Lightner's conscious pain, suffering, and disability, and other harms and losses, including death.

48. WHEREFORE, Plaintiff demands judgment against the Defendants, jointly, in an amount in excess of $25,000.00, together with costs of suit, attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the court finds is appropriate and / or equitable.

FOURTH CAUSE OF ACTION
(CIVIL CONSPIRACY)

49. Plaintiff incorporates all other paragraphs of this Complaint as if fully rewritten herein.

50. Defendants had an express agreement, mutual understanding, or tacit agreement to, and/or their agents maliciously combined efforts to:

a. defraud residents and their families by delivering wholly inadequate care, contrary to their promises;

b. systemically understaff their facilities in violation of federal regulations, and for the purposes of their own profit, at the expense of resident health and safety;

c. under-capitalize the facilities and syphon money to themselves and related entities for the purposes of their own profit at the expense of resident health and safety;

d. inflate resident PDPM levels to obtain excessive and unjustified payments from Medicare and Medicaid while not providing the care paid for with these taxpayer dollars;

e. not provide the level of care, by understaffing the facility, paid for by taxpayer dollars;

f. misrepresenting to Medicare the staffing level of the facility to increase their rating; and

g. as otherwise may be described in the Complaint or learned through discovery.

51. This understanding constitutes a malicious combination to injure residents of the Facility, including Margaret Lightner.

52. In pursuance of this common plan or design to commit tortious acts, the Defendants actively took part in it, or furthered it by cooperation or request, or lent aid or encouragement to the wrongdoers, or ratified and adopted the wrongdoers' acts done for their benefit.

53. The conspiracy caused injury to Margaret Lightner.

54. WHEREFORE, Plaintiff demands judgment against the Defendants, jointly, in an amount in excess of $25,000.00, together with costs of suit, attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the court finds is appropriate and / or equitable.

FIFTH CAUSE OF ACTION
(FRAUD)

55. Plaintiff incorporates all other paragraphs of this Complaint as if fully rewritten herein.

56. Defendants concealed facts concerning their staffing levels, pay, and the amount of care they were actually capable of providing at Warren Nursing & Rehab aka Warren Nursing & Rehab – Providing Onsite Dialysis & Ventilator.

57. Not only did Defendants conceal this information, but they publicly and privately represented that they provide exceptional services in an effort to induce the family of Margaret Lightner and other potential customers to place their loved ones in their care and custody.

58. These inducements were made falsely, with knowledge of their falsity, or with such utter disregard and recklessness as to whether they were true or false that knowledge may be inferred with the intent of misleading Margaret Lightner's family and

other potential customers into placing their loved ones in the care and custody of Defendants.

59. Margaret Lightner's family and the family members of other potential customers reasonably relied on Defendants' representations and concealments regarding the degree of care they provide.

60. The result of these inducements and concealments was that Margaret Lightner's family, and the families of numerous other residents, allowed their loved ones to be placed in the Defendants' facility.

61. As a direct and proximate result of Defendants' actions, representations, and concealments, Margaret Lightner suffered conscious pain and suffering and death.

62. As a direct and proximate result of Defendants' action, representations, and concealments, Margaret Lightner's next-of-kin have experienced harms and losses as a result of their death, including those damages set forth in Ohio's wrongful death statute, Ohio Revised Code section 2125.02 *et seq*.

63. WHEREFORE, Plaintiff demands judgment against the Defendants, jointly, in an amount in excess of Twenty-Five Thousand Dollars ($25,000.00), together with costs of suit, attorney's fees and expenses, punitive and exemplary damages, and any other relief to which the court finds is appropriate and/or equitable.

A TRIAL BY JURY IS HEREBY DEMANDED

Respectfully submitted,

/s/Matthew A. Mooney
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